SECTION 8: Private Duty Nursing Services

Medically necessary private duty nursing (PDN) services are provided when prescribed by a physician and prior approved by the Division of Medical Assistance or its designee.

Residents who are in domiciliary care facilities (such as rest homes, group homes, family care homes, and similar settings) are not eligible for this service. This exclusion does not violate comparability requirements as domiciliary care residents do not have the medical necessity for continuous nursing care. According to State regulations for domiciliary care, people are not to be admitted for professional nursing care under continuous medical supervision and residents who develop a need for such care are to be placed elsewhere. In addition, recipients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, rehabilitation centers, and other institutional settings are not eligible for this service. PDN services are not covered while an individual is being observed or treated in a hospital emergency room or similar environment.

This service is only approvable based on the need for PDN services in the patient's private residence. An individual with a medical condition that necessitates this service normally is unable to leave the home without being accompanied by a licensed nurse and leaving the home requires considerable and taxing effort. An individual may utilize the approved hours of coverage outside of his/her residence during those hours when the individual's normal life activities take the patient out of the home. The need for nursing care to participate in activities outside of the home is not a basis for authorizing PDN services or expanding the hours needed for PDN services.

Medicaid will not reimburse for Personal Care Services, Skilled Nursing Visits, or Home Health Aide Services provided during the same hours of the day as PDN services.

Medicaid Payments for PDN are made only to agencies enrolled with the Division of Medical Assistance as providers for the service. An enrolled provider must be a State licensed home care agency within North Carolina that is approved in its license to provide nursing services within the State.

A member of the patient's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step and in-law relationship) may not be employed by the provider agency to provide PDN services reimbursed by Medicaid.

9. Clinic Services

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

a. Only services furnished by or under the direction of a physician or dentist are covered.

b. Clinic services for which physicians or dentists file directly for payment are not covered.

c. Services specifically covered under other Medicaid programs, e.g., Family Planning or EPSDT, are not reimbursable under the clinic program.

d. Office visits (encounters) to one or a combination of physicians, clinics, hospital outpatient settings, chiropractors, podiatrists, and optometrists are limited to twenty-four (24) per recipient per State fiscal year. Additional visits in excess of the twenty-four (24) visit limit may be authorized by the State agency in emergency situations where the life of the patient would be threatened without such additional care. This limitation does not apply to EPSDT eligible children.

10. Dental Services

All dental services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

a. Routine dental examinations and screening tests are covered for adults and EPSDT recipients, which include adults and children in nursing facilities.

b. Experimental - Dental care that is investigatory or an unproven procedure or treatment regimen that does not meet generally accepted standards of medical practice in North Carolina.

In evaluating whether a particular service is or is not experimental the agency will consider safety, effectiveness and common acceptance as verified through 1) scientifically validated clinical studies 2) dental literature research and 3) qualified dental experts.

c. The services requiring prior approval are: complete dentures, partial dentures, complete and partial denture relines, orthodontic services, periodontal services, elective root canal therapy, and complex or extensive oral maxillo-facial surgical procedures. Emergency services are exempt from prior approval. The Division of Medical Assistance will have the responsibility of prior authorization of dental services.

d. Endodontic treatment is covered for anterior teeth only.

e. Experimental appliances are non-covered services.

f. Payment for full mouth x-ray series is allowed only once every five (5) years.

g. Replacement of complete or partial dentures may be made once every ten years. Replacement after the expiration of fewer than ten years may be made with prior approval if failure to replace the dentures will cause an extreme medical problem or irreparable harm. Initial reline of dentures may only be made if six months have elapsed since receipt of dentures. Subsequent relines are allowed only at five year intervals; if failure to reline in fewer than five years will cause an extreme medical problem or irreparable harm, relines may be made with prior approval. Standard procedures and materials shall be used for full and partial dentures.

h. The state assures that EPSDT eligible clients have access to 1905(A) services not specifically listed in the state plan when they are medically necessary.

.a. Prescribed Drugs

(1) Limited to legend drugs and insulin. Insulin is the only over the counter drug presently covered.

(2) For Non MAC drugs a prescription designated by a brand or trade name for which one or more equivalent drugs are available shall be considered to be an order for the drug by its generic name, except when the prescriber personally indicated in writing or in his own handwriting on the prescription order "DISPENSE AS WRITTEN". For MAC drugs the physician must write in his own handwriting on the face of the prescription "brand necessary", " dispense as written", or words of similar meaning.

(3) Prescription drugs will be limited to six (6) per month per recipient including refills. Additional prescription drugs in excess of the six (6) per recipient per month limit may be authorized by the State agency in emergency situations when the life of the patient would be threatened without such additional services. This limitation does not apply to EPSDT eligible children.

(4) Drugs for which Medical Assistance reimbursement is available are limited to the following:

Covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Act which are prescribed for a medically accepted indication.

As provided by Section 1927(d) of the Act, certain outpatient drugs may be excluded from coverage. Those exclusions are for cosmetic purposes--Rogaine; Retin-A.

All other excludable drugs are covered.

Effective January 1, 1991 Medicaid will cover only drugs of participating manufacturers except 1-A drugs, where state process for approval must be described. (Because of extenuating circumstance waiver, state may cover non-participating manufacturers' drugs for claims with date of service through March 31, 1991.)

A formulary or other restrictions must permit coverage of participating manufacturers' drugs.

The state will comply with the reporting requirements for state utilization information and on restrictions to coverage.

If state has "existing" agreements, these will operate in conformance with law, and for new agreements, require HCFA approval. State must also agree to report rebates from separate agreements.

State must allow manufacturer to audit utilization data.

The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

Prior authorization programs must provide for a 24 hour turnaround on prior authorization from receipt of request and at least 72 hours supply in emergency situations (effective July 1, 1991).

States must cover new drugs of participating manufacturers (except excludable/restrictable drugs) for 6 months after FDA approval and upon notification by the manufacturer of a new drug. The state may put the drug through its formulary but it cannot prior authorize the new drugs and, consistent with the second item above, it must cover drug (again with the exception of excludable/restrictable drugs). The state plan must list the classes chosen for exclusion/restriction or if less than the full class, list the drugs within the class chosen for exclusion/restriction.

The state may not reduce its limits on covered outpatient drugs or dispensing fees effective January 1, 1991 unless it was out of compliance with Federal requirements on November 5, 1990.

12.b. Dentures

(1) Complete and partial dentures are allowed only once in a ten (10) year period. Prior approval is required. Initial reline of dentures may be reimbursed only if six (6) months have elapsed since receipt of dentures. Subsequent relines are allowed only at five (5) year intervals.

12.d. Eyeglasses

(1) All visual aids require prior approval.

(2) No eyeglass frames other than frames made of zylonite, metal or combination zylonite and metal shall be covered.

(3) Eyeglass repair or replacement, or any other service costing five dollars $5.00 or less, shall not be covered.

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services

Services provided under this section are limited to programs for the mentally ill, developmentally disabled and substance abusers certified as meeting the program standards of the Commission on Mental Health, Developmental Disabilities and Substance Abuse Services. These services are available to the categorically needy and the medically needy and include the following specific services:

A. For children who are EPSDT eligible and are found to have physical, mental or developmental problems:

(1) Diagnostic evaluations or assessments designed to identify the existence, nature or extent of illness, injury or other health deviation in a recipient. The service may include a systematic appraisal of mental, psychological, physical, behavioral, functional, social, economic and/or intellectual resources of the individual in order to determine diagnosis and the most appropriate plan for services.

(2) Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders provided to children who are identified through either an EPSDT screen or through another more comprehensive diagnostic evaluation as requiring these services.

3) Subject to prior approval, durable medical equipment, orthopedic appliances including orthotics, prosthetics, and other assistive devices and necessary supplies provided to children who are identified through either an EPSDT screen and/or through diagnostic evaluation as requiring these services.

4) High Risk Intervention, including early treatment, counseling, individual programming designed to intervene in and reduce disability or dysfunctioning and to prevent further deterioration. The service includes education/training services to primary caregivers including family members and teachers.

B. Other diagnostic, screening, preventive and rehabilitative (ODSPR) services for the mentally ill, developmentally disabled and substance abusers are covered benefits when medically necessary. Screening services must be ordered by a physician. Diagnostic, preventive, or rehabilitative services must be ordered by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law.

Covered services are available for persons living in their own homes or in supervised residential situations.

The following services will be covered when a determination is made that the service will meet specific medical and/or remedial needs of the patient. Specific services must be designed to ameliorate diagnosable conditions or prevent the anticipated deterioration of the patient's condition.

Covered services include:

- o case consultation
- o screening and evaluation
- o outpatient treatment (including counseling, therapy, medication monitoring)
- o partial hospitalization
- o Clozapine and related services including clozaril (Clozaril Patient Management System - (CPMS)). This service is limited to regular Medicaid eligible individuals who have a diagnosis of a schizophrenic/ schizoaffective disorder as classified in ICD-9-CM.

14.b Services for Individuals Age 65 or Older in Institutions for Mental Disease

(1) Inpatient Hospital Services

The state agency may grant a maximum of three administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid Agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level-of-care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the

recipient in an appropriate institution within the three day administrative time allowance.

(3) Intermediate care facility services.

(a) Prior approval is required in the following circumstances:

(1) All admissions to intermediate care facilities,

(2) All Utilization Review Committee recommendations that require change in the level of care; however, these recommendations will be taken into consideration at the time of review.

(3) Patients seeking Title XIX assistance in an intermediate care facility who were previously private pay or insured by a third party carrier.

(4) When a patient is discharged from an intermediate care facility to a lower level of care or to his own home, and later returns to a level of care that requires prior approval.

(5) When a Medicaid patient's benefits are terminated for 90 days or more before reinstatement, even though the patient remains in the same facility.

(b) Circumstances that DO NOT Require Prior Approval for Intermediate Care:

(1) An approved patient who is hospitalized and returns to the previously approved level of care.

(2) An approved ICF patient who leaves the facility for an overnight stay provided the absence is authorized by the attending physician.

(3) The Independent Professional Review Team recommends a change in level of care. These recommendations will be accepted.

(c) The form approved for ICF placement is valid for 60 days. If a patient has not been placed during this period of validity, the state or its designated agency should be contacted. At this time, the reviewing nurse will re-evaluate the form and determine if more current information is needed.

15. Intermediate Care Facility Services

Limitations and prior approval same as described in Item 14.b.(3).

a. Intermediate Care Services Including Such Services in a Public Institution for the Mentally Retarded

Limitations and prior approval same as described in Item 14.b.(3).

16. Inpatient Psychiatric Facility Services for Individuals Under 22

The state agency may grant a maximum of three administrative days to arrange for discharge of a patient to a lower level-of-care. With prior approval by the State Medicaid Agency, the hospital may be reimbursed for days in excess of the three administrative days at the statewide average rate for the particular level of care needed in the event a lower level-of-care bed in a Medicaid approved health care institution is not available. The hospital must, however, make every effort to place the recipient in an appropriate institution within the three day administrative time allowance.

Admissions for all out of state psychiatric hospitals including those enrolled as border psychiatric hospitals are subject to prior approval for necessity to go out of state. Services in out-of-state hospitals are provided only to the same extent and under the same conditions as medical services provided in North Carolina.